Please forward this form along with the physician's prescription.

Physical Therapy Pre-Certification Form
Additional Visits /Lower Extremity

QualCare, Inc.
30 Knightsbridge Road
Piscataway, NJ 08854-3754

Patient's Name: ID Number: Group:

Date of Birth: Age: Other Medical Insurance: Yes ☐ No ☐

If yes, Name: Policy Number

If MVA/Other: Date Of Accident Ins. Name: Phone: Policy#

Date of Re-Evaluation: Number of **Completed** Visits:

Primary symptoms:

Duration: Frequency: ☐ Constant ☐ Intermittent

Quality: ☐ Ache ☐ Burning ☐ Numbness ☐ Sharp ☐ Dull ☐ Spasm

Pain Level: (0-10) Current Best Worst Exacerbated by:

Onset Date: Injury due to: ☐ MVA ☐ WC ☐ Other N/A ☐

Lower Extremity

	(**Rt**) ROM Active	ROM Passive	MMT	(**Lt**) ROM Active	ROM Passive	MMT	
Hip Flexion							Functional Limits Mild ☐ Moderate ☐ Severe ☐
Extension							
Abduction							HEP Adherence Yes ☐ No ☐
Adduction							Parethesis Yes ☐ No ☐
Internal Rotation							Tingling Yes ☐ No ☐
External Rotation							Increased ROM Yes ☐ No ☐
Knee Flexion							Increased Strength Yes ☐ No ☐
Extension							Edema Present Yes ☐ No ☐
Ankle Dorsiflexion							Pain w/ Weight Bearing Yes ☐ No ☐
Plantar flexion							Pain Interferes w/ ADL's Yes ☐ No ☐
Inversion							
Eversion							

Additional Information/Special Testing/Deficits:

Diagnosis: (List by ICD 9 Code)

1. 2. 3. 4.

Goals	Short Term	Long Term
1.		1.
2.		2.
3.		3.
4.		4.

Provider: _____ Tax ID Number: _____

Phone Number: Contact Name/ Fax Number:

Pre-Certification Department Fax Number: 732-562-1023

PPO 800-992-6613 (Phone) HMO Network 800-254-0130 (phone)